

Ask patients you are treating for asthma the following two questions:

- **1.** Do your asthma symptoms usually start or get worse when you are at work and get better when you are away from work?
- 2. Are there any materials or activities at your job that you try to avoid because they make your asthma symptoms worse?

If he or she answered "Yes" to either of these questions, your patient may have WORK-RELATED ASTHMA.

Guidelines*to report cases of work-related asthma (new-onset or work-aggravated) to the NJDHSS:

POSSIBLE

Symptoms of asthma and patient-reported work-related temporal pattern of symptoms of asthma

PROBABLE

Diagnosis of asthma

and
patient-reported
work-related temporal
pattern of symptoms
of asthma

CONFIRMED

Diagnosis of asthma and objective evidence of work-relatedness

More detailed information can be found in NJDHSS "Guidelines - Work-Related Asthma Recognition, Diagnosis, and Reporting." To obtain a copy, please visit our Web site or call the NJDHSS (see back of poster for contact information and copy of reporting form).





New Jersey Department of Health and Senior Services Occupational Health Service P.O. Box 360 Trenton, NJ 08625-0360

OCCUPATIONAL DISEASE, INJURY, OR POISONING REPORT FOR PHYSICIANS AND ADVANCED PRACTICE NURSES

INSTRUCTIONS: In accordance with N.J.A.C. 8:57-3.2, physicians and advanced practice nurses must report any patient who is ill or diagnosed with any disease, injury, or poisoning listed below within 30 days after the disease, injury, or poisoning has been diagnosed or treated. In addition, suspect cases or patients with other occupational diseases may be reported. All information MUST be completed. Mail complete report to above address or fax to (609) 292-5677. Additional information, report forms, or business reply envelopes may be obtained from the above address, or by calling (609) 984-1863. This form is also available online in Microsoft Word and in PDF format at www.state.nj.us/health/eoh/survweb.

Date	 	
Date		

available online in Microsoft Word and in FDF forma	PATIENT INFORMATION	
Name of Patient (Print)	TAILET MOMIATION	Date of Birth
(First) (MI)	(Last)	Age (If DOB Unavailable)
Street Address		, igo (ii 202 charanasis)
24.	State Zip Code	Home Telephone Number
City	State Zip Code	
		()
Sex Race White	☐Am. Ind./ Alaskan Native	Hispanic Origin
☐Male ☐Female ☐Black	☐Asian/Pacific Islander	Uotner
	DIAGNOSTIC INFORMATION	
Date of Onset of Disease, Injury, or Poisoning		☐Lead Toxicity, Adult
		(Blood \geq 25 μ g/dl; Urine \geq 80 μ g/L)
///		Blood = μg/dL Urine = μg/L
		☐Arsenic Toxicity, Adult
Diagnosis:		(Blood \geq .07 µg/mL; Urine \geq 100 µg/L)
☐Work-Related Asthma	☐Work-Related Fatal Injury	Blood = μg /mL
□Possible □Probable	☐Work-Related Injury in Children	Urine = μg /L
Confirmed	(Under Age 18)	☐Mercury Toxicity, Adult
☐Extrinsic Allergic Alveolitis		(Blood $\geq 2.8 \mu\text{g/dL}$; Urine $\geq 20 \mu\text{g/L}$)
Silicosis		Blood = μg/dL Urine = μg/L
☐Asbestosis ☐Pneumoconiosis, Other and Unspecific	☐Poisoning Caused by Known or Suspected Occupational Exposure	Cadmium Toxicity, Adult
Occupational Dermatitis	Pesticide Toxicity	(Blood ≥ 5 µg/L whole blood;
Other Occupational Disease - Specify:	Li esticide roxidity	Urine ≥ 3 μg/gram creatinine)
		Blood = $\mu g/L$ whole blood
		Urine = μg/gram creatinine
Name and Address of Laboratory Which Performed	the Testing, If Applicable	
Laboratory Name		
Street Address		
City	State	Zip
AND THE LOCK OF THE PARTY OF TH	PLACE OF EXPOSURE / INJURY	
Company Where Exposure/Injury Occurred		
Name		*
Street Address		Phone No.
City	State	Zip
Patient's Department or Work Location	Job Title or Type	of Work Performed by Patient
-auent's Department of Work Location	000 1110 01 1790	
	AN/ADVANCED PRACTICE NURSE IN	NEOPMATION
Name of Physician or Advanced Practice Nurse (Telephone Number
Name of Filysician of Advanced Fractice Nuise (()
Addross		, ,
Address		
Facility Name		
Street Address		
City		Zip
Indicate Any Reasons Why The Patient Should NOT	be Contacted Comments by Ph	nysician/Advanced Practice Nurse, If Any
CC-31		

REPORTING INSTRUCTIONS: A *Word* or *PDF* version of the reporting form can be downloaded from our Web site at www.nj.gov/health/eoh/survweb. Please send completed forms via fax at (609) 292-5677 or mail to:

New Jersey Department of Health & Senior Services Occupational Health Surveillance Program PO Box 360 Trenton NJ 08625-0360

Questions? Contact the Work-Related Asthma Surveillance Coordinator at (609) 984-1863 or send an e-mail message to surveillance@doh.state.nj.us.